Johnston Acupuncture Clinic www.JohnstonAcupunctureClinic.com

1343 Hartford Ave., Suite 1, Johnston, RI 02919
Telephone (401)861-7555 Fax (401)861-3767

## NEW PATIENT REGISTRATION INFORMATION

(All information is strictly confidential)

(Please Print) Date_____

Name_____ Age_____ Date of Birth _____
(Last) (First) (Middle Initial)

Address_____City_____ State_____ Zip_____

Phone (Home) _____(Cell)_____E-mail _____

Sex: Male Female Marital Status: Single Married Divorced Widowed Separated

Employer _____ Occupation_____

Address_____ City_____ State_____ Zip_____

Name of Spouse (or Parent, if Minor) _____ Occupation_____

Person Responsible for Account _____ Phone No. _____

Address_____ City _____ State _____ Zip_____

Whom Do We Thank for Referral to Our Office? _____

**Person to Contact In Case of Emergency** _____ **Phone No. __**_____

Physician's Name_____ Phone No._____

Address _____ City _____ State _____ Zip _____

Primary Insurance Co._____ Phone No. _____

Address _____ City _____ State _____ Zip_____

Subscriber's Name_____ Relationship to Patient _____

Subscriber's Date of Birth_____ Group No._____ Policy No. _____

Secondary Insurance Co. (if any) _____ Phone No._____

Address _____ City_____ State _____ Zip_____

Subscriber's Name_____ Relationship to Patient _____

Subscriber's Date of Birth_____ Group No._____ Policy No._____

Please Check If Covered Under: ☐Worker's Compensation ☐Automobile Insurance Policy

Some insurance policies provide acupuncture coverage, but benefits vary from company to company and policy to policy. Therefore, although we will fill out insurance forms, the patient is personally responsible for payment of services rendered. We do accept insurance assignments but all insurance arrangements must be approved in advance.

I am aware of my responsibility for acupuncture and adjunctive services rendered by Dr. Rodger Zeng. I authorize payment of medical benefits to Dr. Rodger Zeng. In addition, I give permission for the release of any information requested by any insurance companies, or any other third party payers.

Signature of Patient _____

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**Name** _____

**Main Complaint:** _____

**Other Concurrent Therapies:** _____

**Medical History**

Significant Illnesses:

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Heart diseases ☐ Hepatitis ☐ Thyroid disease ☐ Seizures

☐ Other _____

Surgeries:_____ Significant Trauma: _____

Allergies: (drugs, chemicals, foods) _____

Medicines taken within the last two months _____

Exercise _____

Other _____

**Average Daily Diet**

Breakfast _____ Lunch _____ Dinner _____

**Habits**: ☐ Cigarettes ☐ Alcohol ☐ Coffee ☐ Tea ☐ Soda ☐ Sugar ☐ Other_____

**Family Medical History**

☐ High Blood Pressure ☐ Heart Diseases ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Asthma ☐ Allergies

☐ Seizures ☐ Alcoholism ☐ Other_____

**GENERAL**

| | | | |
|---|---|---|---|
| ☐ Poor appetite | ☐ Cold hands | ☐ Fatigue | ☐ Tremors |
| ☐ Heavy appetite | ☐ Cold feet | ☐ Poor coordination | ☐ Cravings _____ |
| ☐ Change in appetite | ☐ Cold back | ☐ Localized weakness | ☐ Strong thirst (cold/hot drinks)_____ |
| ☐ Poor sleep | ☐ Cold abdomen | ☐ Sweat easily | ☐ Peculiar tastes/smells _____ |
| ☐ Heavy sleep | ☐ Fever | ☐ Night sweats | ☐ Bleed or bruise easily (where)_____ |
| ☐ Insomnia | ☐ Chills | ☐ Vertigo | ☐ Sudden energy drop (at time) _____ |

☐ Other _____

**SKIN AND HAIR**

| | | | |
|---|---|---|---|
| ☐ Itching | ☐ Ulceration | ☐ Dandruff | ☐ Purpura |
| ☐ Rashes | ☐ Eczema | ☐ Loss of hair | ☐ Change in hair/skin texture |
| ☐ Hives | ☐ Pimples | ☐ Other _____ | |

**HEAD, EYES, NOSE, EARS, AND THROAT**

| | | | |
|---|---|---|---|
| ☐ Dizziness | ☐ Night blindness | ☐ Ringing in ears | ☐ Sores on tongue |
| ☐ Concussions | ☐ Color blindness | ☐ Poor hearing | ☐ Facial pain |
| ☐ Migraines | ☐ Cataracts | ☐ Earaches | ☐ Jaw clicks |
| ☐ Headaches | ☐ Blurry vision | ☐ Dry throat | ☐ Teeth problems |
| ☐ Eyestrain | ☐ Spots in eyes | ☐ Sore throat | ☐ Gum problems |
| ☐ Eye pain | ☐ Sinus problems | ☐ Sores on lips | ☐ Grinding teeth |
| ☐ Poor vision | ☐ Nose bleeds | | |

☐ Other _____

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**Name** _____

**CARDIOVASCULAR**

☐ High blood pressure ☐ Irregular heartbeat ☐ Swelling in hands ☐ Difficulty breathing
☐ Low blood pressure ☐ Dizziness ☐ Swelling in feet ☐ Phlebitis
☐ Chest pain ☐ Fainting ☐ Blood clots
☐ Other_____

**RESPIRATORY**

☐ Asthma ☐ Pneumonia ☐ Coughing blood ☐ Difficulty breathing
☐ Bronchitis ☐ Cough ☐ Chest Congestion ☐ Phlegm(color, if any) _____
☐ Other_____

**GASTROINTESTINAL**

☐ Nausea ☐ Gas ☐ Diarrhea ☐ Bloody stools
☐ Vomiting ☐ Belching ☐ Constipation ☐ Rectal pain
☐ Sensitive Stomach ☐ Bad breath ☐ Black stools ☐ Hemorrhoids
☐ Abdominal Pain ☐ Bowl movement: Frequency _____, Form _____, Color _____, Odor _____
☐ Other_____

**GENITO-URINARY**

☐ Frequent urination ☐ Unable to hold urine ☐ Bloody urine ☐ Kidney stones
☐ Urgency to urinate ☐ Pain on urination ☐ Impotency ☐ Venereal diseases
☐ Wake up to urinate: How often? _____ times/night
☐ Other _____

**PREGNANCY AND GYNECOLOGY**

☐ Age at first menses _____ ☐ Flow(describe)_____ ☐ Last PAP _____ ☐ Last menses _____
☐ Period (days) _____ ☐ Clots ☐ Breast lumps ☐ Menopause _____
☐ Duration _____ ☐ Irregular periods ☐ Changes in body/psyche prior to menstruation
☐ Number pregnancies ___ ☐ Number births _____ ☐ Premature births _____ ☐ Miscarriages _____
☐ Other_____

**MUSCULOSKELETAL**

☐ Muscle pain ☐ Neck pain ☐ Back pain (where) _____ ☐ Joint pain (where) _____
☐ Other _____

**NEUROPSYCHOLOGICAL**

☐ Seizures ☐ Concussion ☐ Poor memory ☐ Bad temper
☐ Easily stressed ☐ Depression ☐ Anxiety ☐ Treated for emotional problems
☐ Considered/attempted suicide ☐ Areas of numbness_____
☐ Other_____

**COMMENTS** _____

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# INFORMED CONSENT

During the treatment procedure, sterilized, disposable needles are used to eliminate the possibility of transmitting a communicable disease by a contaminated needle.

After treatment, the patient may notice a spot of blood at one or more of the needle sites, or small bruise may develop. These should not be harmful and the bruise will disappear in a few days.

If necessary, a technique known as “Moxibustion” may be used in addition to the insertion of needles. “Moxibustion” is a technique, which uses heat supplied by the burning of the herb “Artemisea Vulgaris”. Indirect moxibustion is employed more frequently than direct moxibustion. However, in certain cases, it will be beneficial to place the “moxa” directly on the skin at the acupuncture points. This treatment may involve some slight discomfort and, as a result of the treatment, a small blister may appear on the surface of the skin and small scar may result.

A Chinese treatment technique called Cupping may be used in certain cases. Another Chinese Technique called “Gua Sha” May also be used. “Gua Sha” is technique of scraping the skin with a smooth–edged instrument in order to elicit a redness of the skin. After the treatments, there will be bruise marks at the site of application. These will fade away in a week or less.

In some cases, electrical stimulation of the needles may be indicated. This procedure involves the use of a small, battery powered electrical stimulator, which is attached with wires to the ends of the needles after they have been inserted or to magnets taped to the skin surface.

To provide constant stimulation, tiny inter-dermal needles or press tack needles may be taped in places to continue treatment between office visits. If any discomfort occurs due to friction of clothing or for any other reason, the patient may remove the needles by pulling off the tape.

Payment is required upon rendering of service. **If a 24-hour notice is not given for appointment changes or cancellations, the time may be billed.**

I have read the above information and will discuss all questions related to my treatment and the above procedures with the doctor of acupuncture.

Name (print) _____

Signature _____ Date _____/_____/_____

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# Knowledge of the Notice of Privacy Practices

I hereby certify that I was given the Notice of Privacy Practices by staff in Johnston Acupuncture Clinic, and I have read it. If necessary, I will discuss any questions related to the Notice with the contact person in the office.

Name (print) _____

Signature _____ Date _____/_____/_____

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**NOTICE OF PRIVACY PRACTICES**

*THIS NOTICE DESCRIBES HOW WE, JOHNSTON ACUPUNCUTRE CLINIC, MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO YOU HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.*

This Notice of Privacy Practices became effective on April 14, 2003

**OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share your health information. We also describe your rights and certain duties we have regarding the use and disclosure of your health information.

**OUR RESPONSIBILITIES**

Law Requires Us to:

Keep your health information private.

Give you this notice describing our legal duties, privacy practices, and your rights regarding your health information.

Follow the terms of this Notice that is now in effect.

We Have the Right to:

Change our privacy practices and the terms of this Notice at any time, provided that the changes are permitted by law.

Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes. If we change this Notice, the new Notice of Privacy Practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

**USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your health information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by your writing to us.

We may use the health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share the health information about you to your other health care providers to assist them in treating you.

We may use and disclose your health information for payment purposes.

We may use and disclose your health information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

We may disclose your health information to a family member, your personal representative or another person involved in your care.

We may be required to disclose your health information in the course of any judicial or administrative proceedings in response to a legal order or other lawful process, including a subpoena.

We may use and disclose your health information as required to comply with workers compensation laws and other programs that provide benefits for work related injuries or illnesses.

We may disclose your health information for health related research.

We may disclose your health information to prevent a serious threat to public health or safety.

We may disclose your health information to business associates who perform health care operation for us and who commit to respect the privacy of your medical information.

We may disclose your health information to governmental authorities about victims of suspected abuse, neglect, or domestic violence.

**YOUR LEGAL RIGHTS REGARDING YOUR HEALTH INFORMATION**

You may, by sending a written request to the office contact person at Johnston Acupuncture Clinic at the address shown at the beginning of this Notice, request that we restrict our uses and disclosures of your health information for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you request.

You may, by sending a written request to the office contact person at Johnston Acupuncture Clinic at the address shown at the beginning of this Notice, request that we communicate with you in a confidential way, such as calling specific phone number, mailing health information to a different address, or sending e-mail to your personal e-mail address. We will do our best to accommodate these requests if they are reasonable, and if you pay for any extra cost.

You may, by sending a written request to the office contact person at Johnston Acupuncture Clinic at the address shown at the beginning of this Notice, request to see or to obtain photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within thirty (30) days after we have received your request. You may have to pay for the photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one thirty (30) day extension of the time for us to give your access or photocopies if we send you a written notice of the extension.

You may, by sending a written request to the office contact person at Johnston Acupuncture Clinic at the address shown at the beginning of this Notice, request an amendment of your health information if you think that is incorrect or incomplete. If we agree, we will amend the information within sixty (60) days of receiving your request. We will send the corrected information to persons or organizations that we know received the wrong information, and others that you may specify. If we do not agree, you may write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we have on thirty (30) day extension of time to consider your request of amendment if we notify you in writing of the extension.

You may, by sending a written request to the office contact person at Johnston Acupuncture Clinic at the address shown at the beginning of this Notice, request a list of the disclosures that we have made of your health information within the past six (6) years (or a shorter period). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will be required to pay for them in advance. We will usually respond to your request within sixty (60) day of receiving it. By law, we can have one thirty (30) day extension of time if we notify you of the extension in writing.

You may, by sending a written request to the office contact person at Johnston Acupuncture Clinic at the address shown at the beginning of this Notice, request additional copies of this Notice of Privacy Practices, no matter whether you have already had one electronically or in paper.

**COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us, the U.S. Department of Health and Human Services, or the Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at Johnston Acupuncture Clinic at the address shown at the beginning of this Notice.

**FOR MORE INFORMATION**

If you want more information about our privacy practice, please call or visit the office contact person at Johnston Acupuncture Clinic at the address or phone number shown at the beginning of this Notice.